Oldfield Residential Care Ltd

Norton Grange Nursing & Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 22 November 2017 and was unannounced.

Norton Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Norton Grange accommodates 27 people in one adapted building. The home has two floors. It provides nursing care to older people who live with dementia. On the day of our visit 22 people lived at the home and one was in hospital.

The registered manager recently left the service without working her notice of resignation. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected Norton Grange in November 2016 and gave the home an overall rating of 'requires improvement'. There were no breaches of the regulations. During this inspection visit we found further improvements were required and two breaches of the regulations. This is the third consecutive time the service has been rated as requires improvement.

The acting manager and acting assistant manager were being supported by the provider's operational director to address issues that had recently been identified at the home, and to increase their knowledge and gain confidence in their roles.

At this inspection one person who lived at the home had not been allowed to leave the premises without an escort. This was, in the opinion of the manager, in the best interest for their safety. However the person did not want escorting and had the capacity to make this decision. Some of the authorised Deprivation of Liberty Safeguards had expired, and new applications had not been submitted. This meant the provider was not meeting the requirements of the Mental Capacity Act.

Since our last inspection visit there has been a high turnover of staff at the home. This has meant staff from an agency have had to cover the vacant positions and led to a reduction in the continuity of care experienced by people. The use of agency staff was now decreasing and there were enough staff on duty to meet people's needs.

Medicines were mostly managed and given to people safely, however on the day of our visit we found one person had not been given their medicine in line with their care plan.

Risks to people's health and well-being had mostly been identified. However there were times when the changes in the risks to people had not been updated or written in records to support staff in their knowledge.

The assistant manager and staff understood their responsibilities to protect and safeguard people from abuse. Recruitment practice supported the recruitment of people who were safe to work with people with complex health and social care needs.

Staff had received sufficient training to meet people's needs. Some of the training to refresh staff skills and knowledge had not been provided within the timeframe expected by the provider.

People were provided with a choice of food at breakfast and tea time, but did not think they always had a choice at lunchtime. Most people enjoyed the meals provided. People with specific dietary needs were supported with these.

People's health needs were supported by nursing staff who worked at the home and through timely referral to other healthcare professionals.

Staff were kind and caring towards people. They treated people with dignity and respect. There was a good atmosphere in the home.

People who lived on the first floor dementia unit had more opportunities than those on the ground floor to engage with staff on a social level, and to participate in activities.

The premises and equipment were safe for people to live in and use. The building was undergoing renovation work at the time of our visit to increase the number of people who lived at the home and to improve the ground floor lounge facility. New furniture had been ordered to improve the homeliness of the service.

Staff told us the atmosphere in the home had recently improved and they felt listened to and supported by the new acting managers. They felt the new managers were open and transparent. There were quality assurance processes but these did not always identify where shortfalls had occurred.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

There were enough staff on duty to keep people safe, but there had been a high level of agency staff working at the service which had only recently reduced. This meant people had experienced a reduction in continuity of care. Risks related to people's care were mostly minimised. Medicines were mostly given safely. Staff recruitment procedures reduced the risks of employing unsuitable staff. The premises and equipment were safe for people to use.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff did not always work to the principles of the Mental Capacity Act. They had mostly received training and support to provide effective care to people and to understand people's needs. People did not know they could always receive a choice of meals, but most enjoyed the food provided. People received the healthcare they needed from nursing staff and had access to other healthcare professionals when required.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful to people. Staff supported people to maintain their dignity and privacy. There was a happy atmosphere in the home and a good rapport had been established between people and the staff who supported them. Visitors were welcome to the home.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Most people received staff support which was responsive to their emotional and social needs. People and relatives felt concerns would be listened to. However, complaints had not been responded to in line with the provider's complaints policy and

procedures.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

The registered manager had recently left the service. The acting assistant manager and acting manager were being supported by the operational director to improve the service and gain management skills and knowledge. The staff team felt the new management structure was supportive of them, and open to their ideas. There were quality assurance processes but these did not always identify where shortfalls had occurred.

Norton Grange Nursing & Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 November 2017 and was unannounced. The inspection team consisted of an inspector, a specialist nursing advisor for dementia, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service including the statutory notifications the manager sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority and clinical commissioning staff to find out their views of the service. Their views were similar to what we found during the course of our inspection visit.

During our visit we spoke with five people who lived at the home, five relatives and friends, four care staff, one nurse, the acting manager, acting assistant manager, and the operational director. We spent time with people and staff looking at the care provided to people, and reviewed the care plans of five people in detail. We also reviewed other records to demonstrate the provider monitored the quality of service such as staff meeting minutes, staff training plans, audit checks, provider visit records, accident and incident records, health and safety and medicine records.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection on 15 November 2016 this key question was rated as 'Good.' During this inspection we found improvements were required.

People who lived at Norton Grange and their relatives told us they felt they or their loved one was safe at the home. One person said, "Of course I feel safe here. I have a tendency not to sleep and so I have a walk around. I'm happy here." A relative told us, "My husband is safe here."

Since our last inspection there had been a high turnover of staff. The provider's information return (PIR) which was sent in July 2017 informed us 46 staff had started work at the service in the last 12 months and 23 staff had left. The week prior to the PIR being submitted, the provider had to use agency staff (people employed by another agency, to work in homes which are short of staff and need cover from appropriately skilled and qualified staff) for 312 hours that week. A high turnover of staff meant people were not always getting continuity of care from a staff team they knew and who they had over time developed trusting relationships with.

The acting manager and the operational manager acknowledged to us there had been a high turnover of staff. They said they still needed to use agency care staff and nursing staff but the use of agency staff had decreased since the high point of the summer and people were now being cared for more by staff they knew. They told us their own care staff were now able to cover the rota for the day time, but there remained some vacancies for night staff. The operations director confirmed the home never went short of staff.

Whilst there remained some issues in relation to the continuity of care provided to people, we found there were enough staff to meet the needs of people on both floors of the home. We checked the recruitment records of two new staff. These showed references from previous employers and character references had been obtained, and the Disclosure and Barring Service (DBS) checks had been completed. The DBS is a national agency that keeps records of criminal convictions.

We looked at how risks to people's health and welfare were managed. Written risk assessments provided sufficient information about the risks related to people and how these could be minimised. However, during our inspection, whilst speaking with a visiting relative in a person's bedroom, we found a pill lying on the person's bedside table. The relative told us the person had a history of spitting tablets out and not swallowing them. We checked the medicine administration record which had been completed to confirm that the medicine had been administered. However, it was clear the staff member had not followed the person's care plan which clearly stated this person had a tendency to spit out medicines, by checking to see if the medicine had been swallowed.

We looked at how other medicines were administered to people. People told us they received their medicines as prescribed. For example, one person said, "My medication is done correctly both morning and afternoon. I have my medication in the morning between 8am & 9.30am." We saw a nurse support people to take their medicines at lunch time. They made sure people had their prescribed medicines, and asked those

who were on 'as required' medicines (for example, medicines administered for pain relief) if they needed them. Medicine records informed nursing staff how people wanted to be given their medicines, for example, whether they wanted them to be given by spoon, or for the medicines to be put in their hand. Other medicine records accurately recorded the medicines given to people.

Building work was being undertaken in the home to improve the quality of life of people who lived there. We were told risk assessments had been written to ensure people's needs were accounted for during this time and measures taken to reduce any potential risks.

During our visit we found a fire door was wedged open with a towel. A person who lived in the home told us this was because they liked to go outside to smoke a cigarette and the door was wedged open so they did not have to wait for staff to support them.

We informed the acting manager about the fire doors being wedged open. They told us the fire doors should not be wedged open, and went on to say the person's access to the garden had changed because of the building work, and previously they had been able to go out to the garden via a non fire door. None of this had been considered in the person's risk assessment.

Whilst looking at this person's care record, we found there was no risk assessment in relation to their smoking. The record told us the person's clothes had caught fire and the fire had to be put out to keep the person safe. This was because a lit cigarette had ignited the clothes they were wearing. We were told the previous manager had agreed with the person they would not have a lighter, and instead one was installed and secured in the smoking shed so they could go out and have a cigarette. None of this was written in their care plan so agency staff, or staff new to the home would not know by looking at the records, the actions taken to reduce the risk of this happening again. The acting manager said they would make sure there was a risk assessment written regarding the person's smoking.

We checked whether people at risk of developing pressure sores and who slept on mattresses which had air rotating within the mattress, had their mattresses air flow at the right setting for their weight. One person had their setting set to 'mid'. The staff could not explain why this was. The person had some skin damage which had healed but without knowing whether the setting was correct for the person's weight, their skin may have taken longer to heal and it may have contributed to the person's discomfort.

We looked at infection control measures in the home. Staff understood their responsibilities to wear protective equipment such as gloves and aprons when they supported people with personal care. They also understood how to ensure laundry was safely laundered so that contaminated laundry was washed separately and at higher temperatures than non-contaminated laundry.

People told us they found the home clean. One person said, "It's always clean here, my room is spotless." A friend of a person also said, It's always clean here." The home had been given a five star rating by the food hygiene authorities for the kitchen's cleanliness. However, on the day of our visit we found some parts of the home were not clean. For example, some of the flooring in people's rooms was dirty. Staff told us there were times when there were no housekeepers on their floor to support the cleaning required, and there were also issues with night staff undertaking their cleaning duties as well as they should. The regional manager told us there had been vacancies for housekeeping and this might be why there were times there was not housekeeping support on each floor, but this should not be the case now. They said they were looking at the cleaning schedules and process for the housekeepers and the night staff to make them more robust.

The premises were secure, and records demonstrated there were regular checks for fire, gas, electric, and

water safety, and to make sure the equipment used was mechanically safe. The maintenance worker undertook maintenance tasks in a timely manner, and we saw one person who lived in the home had provided positive comments to them in the 'maintenance book' about the work they had done.

People had individual evacuation plans to help fire and rescue services evacuate the premises if the need ever arose.

Staff understood the principles of safeguarding people who lived at the home from harm, and knew their responsibilities to report any unsafe practice to the manager. The acting manager was aware of their responsibility to report these concerns to the local authority safeguarding team and to the CQC. In the last year the previous registered manager reported safeguarding concerns to the CQC and kept the inspector informed of on-going investigations. People's money had recently been audited by the acting manager and deputy manager and found to be in good order.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in November 2016 we rated this key question as 'good'. During this inspection visit we found improvements were required.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's capacity was being assessed to determine whether they were able to make their own choices and decisions or whether they needed support from others to make decisions in their best interest. Most people who lived in the home did not have capacity to make complex decisions or to safely leave the building without putting themselves at risk. We found some people without capacity who legally required their liberty to be restricted did not always have the authorisations in place to do so. This was mostly because previous authorisations had expired and further authorisation had not been requested. Records showed this had been identified by the operations director during the time the previous manager worked at the home. The acting manager and operational director were in the process of submitting applications to the local authority safeguarding team.

During our visit we were approached by a person who lived at the home who told us they were being stopped from going out of the building on their own. They said to us, "I can't go out because I have to have a carer with me. I don't know why I can't go out. There's no reason for it. Will you find out why I can't go out on my own?" We looked at the person's records and found they had been assessed as having full capacity to make their own decisions. Despite this, a DoLS application had been made. The 'best interest assessor' (a person who checks whether a person needs a DoLS) had informed the registered manager they had concluded the person had capacity and therefore would not have the DoLS application approved. This meant the person had been deprived of their liberty unlawfully. The acting manager explained they had escorted the person when they were out of the home to keep them safe as they felt this was in the person's best interest. However, the law says that people who are deemed to have capacity are free to make unwise decisions which might place them at harm. The acting manager told us the person had become much better since their arrival at the home and they had already spoken with the person's social worker about whether a different environment might be more appropriate for their needs.

This was a breach of Regulation 11 of the health and Social Care Act 2008 (Regulated activities) Regulations 2014. Need for consent.

Staff told us they had received training in the Mental Capacity Act and they understood the importance of, where possible, gaining people's consent before supporting them with care. We saw this in action. They also

understood that where a person did not have capacity to make decisions, these could be undertaken in the person's best interest. However, none of the staff had questioned whether the person who had capacity should be free to leave the building. Nurses understood their responsibilities under the MCA and knew that medicines given in disguise (covertly) could only be given in a person's best interest once a GP and pharmacist had agreed to this.

People and their relatives felt staff had the skills, knowledge and experience to deliver effective care and support. One person told us, "The staff are well trained." A relative said, "The staff are supportive. I think they are well trained."

Nursing and care staff told us they felt they had received the training they needed to support people. For example, One person was fed via a PEG (this is a tube which allows nutrients, fluids and medicines to be put directly into the stomach. The care plan for this was in place and was regularly reviewed by the nurse in charge. Care staff were able to tell us about the PEG feed and how it was administered. Another person lived with epilepsy. Staff understood how and when to administer emergency medication to stop prolonged convulsions.

Permanent staff said they had received regular supervision from their manager, and felt the new manager and assistant manager were good at listening to them and providing support. The acting manager had identified areas where staff had not received their training within the provider's expected timeframe and had acted on this. For example, training to ensure staff knew how to move people safely, had been delivered prior to our inspection visit, and fire training was scheduled for 5 December 2017.

We had mixed opinions about the quality of food provided. One relative said, "He loves his food. He always eats it all." Another said, "When we've been here the food looks very good." Whereas another relative said, "I don't think that the food's very nice."

At a previous inspection in December 2015 we found people did not have a choice of mid-day meal. This had been rectified when we last visited the home in November 2016. During this visit we found conflicting views as to whether people routinely had a choice of meals. One person said to us, "There's a good choice at breakfast. I can have what I like. I usually have bacon and eggs. I eat late in the morning and so I have a late dinner. We don't have any choice at dinner time. Today it was gammon and vegetables. It was OK. For tea we have a choice. We can have jacket potato and there's a selection of sandwiches." A relative told us, "Today he had porridge and toast for his breakfast. There doesn't appear to be a choice with the food – they just bring it."

We discussed this with the regional manager and acting manager. The acting manager told us there was always a choice for people even if there was only one advertised meal on the menu. They said there were two options provided on the menu four out of the seven days each week. When only one option was advertised, people could still ask for an alternative such as a jacket potato, or an omelette. They acknowledged this wasn't made clear and said they would make sure people knew they could always have a different option if they did not like what they saw on the menu.

People who needed their meal in a 'soft' or 'pureed' form were provided with these so that they could still distinguish the different foods on the plates, colours and flavours. Those who sat in the lounge/dining room to eat their meals were seen to enjoy the meal provided. However, they were not supported to move to the dining room tables to eat their meal, with most eating their meals on a tray table. This meant there was no opportunity for social interaction and engagement. We were concerned that people were not always supported to eat independently. One relative told us, "I have been here at lunch time and a carer was

feeding him. He doesn't need to be fed, he can feed himself."

We checked how one person was supported to eat their meal in their bedroom. The person could eat their meal independently, but the staff member had positioned their bedside table in such a way it was difficult for them to eat their meal without food falling on to them. The plate did not have a plate guard to reduce the risks of this happening, and the person was not supported to adequately sit up to help them eat their meal. We asked the acting manager to look at what we saw. They immediately told us how the person's meal should be delivered to them, and rectified the situation. Once this was done, we saw the person enjoy their meal.

The provider had their own dietician who supported those who lived at the home who had specific dietary needs and who required additional support. People's weights were monitored and one person who had lost weight had been referred to the dietician, and their weight had stabilised. Staff understood the cultural and religious food requirements of those who lived in the home. People were encouraged to drink regularly.

People felt they had access to healthcare services and received on-going healthcare support. One relative told us, "A carer took [person] to the hospital for a CAT scan last week. And next week a carer's taking him to the hospital for a CT scan." They went on to tell us because of the time of the appointment, they could not attend with their relative and were pleased that staff were going to provide support for them to go.

A GP visited the home once a week. A person told us, If I am ill I always see a doctor." Nursing staff told us they had a good relationship with the surgery. They said there could sometimes be issues with medicines required between regular orders but they were working with the surgery and pharmacy to improve this.

Building work was in progress to add one more bedroom to each floor and to increase the size of the lounge area for people who lived on the ground floor. On the first floor a coal effect fire place had been installed to make the lounge area more homely and new lounge furniture was due to be delivered to again provide a more homely atmosphere. The regional manager told us that settees had also been bought for the corridors so people could sit and rest during their walk down the corridor or if they wanted somewhere else other than the lounge area to sit.

Good

Is the service caring?

Our findings

At our previous inspection in November 2016 we rated this key question as 'good.' We continued to see staff being caring to people who lived at Norton Grange.

During our visit we saw staff treated people with kindness and respect. All the people we spoke with were complimentary about the staff who worked at Norton Grange. They told us, "The staff are kind to me." "The staff are all very good here," and, "The staff are very kind and caring towards me."

We spent time in the dementia unit seeing how staff engaged with the people who lived there. We saw staff were respectful in their approach to people. When communicating with people they made sure they were at eye level, listened to what people said and appeared interested in their thoughts.
One person within the home told us," The staff show an interest in me."

Staff understood how to respect people's privacy and dignity. Personal care was provided behind closed doors, and staff understood the importance of privacy. One person told us they liked to have their door left open but staff always knocked on the door before they came into their room. Another said, "The staff show me respect. They always knock the door before they come in and they explain what they are doing."

Care records were written from the perspective of the individual, and permanent staff were knowledgeable about people's needs. One person said to us, "The staff know me, they know what I like to do." Another said, "They ask me what I like and don't like." A friend of a person said, "The staff seem to know my friend well. They know what he likes. They're kind to him and talk to him."

All staff seemed to have a good understanding of people's likes and dislikes and their differing personalities, and they all appeared cheerful, helpful and generally enjoyed their work.

During the day we saw staff supported people to express their views and be involved in the day to day decisions about their care. For example, this included whether people wanted to sit in the lounge or be in their bedroom, or whether they wanted to join in with the party which had been planned for that evening.

Relatives we spoke with were also complimentary of the staff at Norton Grange. They said, "The staff are very kind, we are made to feel welcome;" "The staff are kind and caring here;" and, "The staff are always welcoming to me. They speak to me."

Both people and relatives told us there were no restrictions on visiting time. One person said, "I have visitors. They come whenever they want to." Another said, "My family can visit me anytime they like." Relatives said the same, and told us the staff were not only kind to their relation but also to them as visitors.

Staff appeared happy and supportive of the people they provided care for. Staff told us there was a better atmosphere in the place and they felt happier in their work. Care staff told us they now felt supported and cared for by management. They said they did not feel this previously. They felt this improved the quality of

care provided to people who lived in the home.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in November 2016 we rated this key question as 'good'. During this inspection visit we found improvements were required.

At our last visit we found staff on the dementia unit had enough time to engage with people but staff on the ground floor felt they did not have enough time to engage with people other than when supporting them with personal care or other tasks. During this visit we found the same. There were six staff on duty on the dementia unit in the morning and seven in the afternoon to support 12 people; and two staff on the ground floor general nursing unit to support 10 people (two of whom required minimal support). There were no activity workers at Norton Grange. This was because the staffing levels took into account people's social and emotional needs, and the provider felt there were sufficient staff to ensure these needs were supported. The ground floor staff did not have much time to engage with people on a social or emotional basis. One person we spoke with appeared to be very lonely. They told us they spent a lot of time in their room alone.

On the ground floor building work was taking place. People were not able to use the lounge as building work was being undertaken to improve the lounge facility. People had been informed of this. One person said, "I knew about the building work before it started. They told me about it and what was happening." Because of this, we could not see how well staff were able to meet people's emotional and social needs. We asked a member of staff to tell us how much engagement they had with people. They told us there was usually a group of people who sat in the lounge which made it easier to speak with people. They said it was sometimes difficult to sit and talk with people because people were mainly using their bedrooms whilst the work was being completed.

We saw most people on the first floor dementia unit preferred to sit in the lounge area. This meant staff were more available to meet their needs and to respond to their requests. There was a kitchen area next to the lounge which meant staff could respond quickly to people's needs for snacks and drinks; and there was always at least one member of staff to respond to any care support needs.

During the day we saw people on the dementia unit involved in individual and group activities. A care worker told us they had recently been able to buy new activities for the dementia unit after requesting these for a long time. In the afternoon we saw a care worker play a parachute game with a number of people. We saw one person who required one to one support, went out with a care worker to a burger restaurant. Other people and their relatives told us they went out with staff support. For example, one person said, "I don't go out on my own. I went out last week to the shops." A relative told us, "He can't go out on his own but he does go out with someone with him."

During the early evening of our visit, people enjoyed a party at the home. An external singer had been booked to sing at the party. One person told us, "I sometimes join in with the activities. Today there's going to be a singer upstairs – I'll probably go along. I enjoy it when a singer comes." We saw people enjoyed the entertainment and the food. Whilst it was only November, this was seen as part of the Christmas festivities and people were wearing Santa hats. Earlier in the day we saw people and staff make Christmas decorations

for the party.

We did not see people being involved in the monthly reviews of their care. One person told us, "I haven't been asked about my needs. I don't feel involved in my care." We saw at least three people who could have been fully involved in care reviews, but their views of their care were not sought. There were other people who could have had some involvement in reviewing the care such as being asked if they got enough baths or showers, or if they liked the staff who supported them. We discussed this with the acting manager who said they would look at how they could improve the involvement of people in ensuring they got the care in the way they wanted.

We were informed of occasions where staff had been responsive to people's needs. For example, a person who had 24 hour one-to-one care had a better relationship with some care workers than others. This was considered when the rota for their support was arranged to try to make sure the care workers who supported them were ones they preferred. A relative also told us that the home had responded to concerns they had about the impact one person's behaviour was having on their relation. The home moved their relation to a different part of the home and this had made them more settled.

We asked whether there were people who lived in the home who had a disability, impairment or sensory loss who required other means of communication other than verbal communication. The acting manager told us a person used a communication board to help them communicate with staff. They were also in the process of buying a new communication board to support them to visually communicate with those who found verbal communication a challenge.

The home had people from different ethnicities and cultures. Their needs had been discussed as part of their care planning to ensure they received the care they required. We asked whether there was anyone living at Norton Grange who identified themselves as part of the LGBT community (Lesbian, gay, bisexual or transgender). We were told by the acting manager there currently was no one who identified as LGBT but they would welcome people who were. We looked at the pre-admission information and it was agreed this did not support staff to ask questions which would help people to be open if they wished to, about their sexual identity. The acting manager said they would change the form.

Staff had worked with relatives and people to find out their life histories to help them understand people, and to provide topics of conversation and reminiscence.

We asked people and their relatives if they felt able to complain if they had any concerns. One person said, "There is no need for me to complain – it's OK here. I do know how to make a complaint and I would make one if there was a need." Another said, "No I don't have any complaints. If I did have a complaint I would be comfortable telling the staff. I also have a social worker and so I can talk to her." Relatives mostly told us they had not needed to complain. One told us they had previously complained about items of clothing getting lost when they went to the laundry. They told us this wasn't happening now.

We looked at how three formal complaints had been managed. We were concerned because they did not reflect the complaints policy and procedures of the provider. These complaints had been filed prior to the acting manager taking on managerial responsibility. She was aware of how to manage complaints.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in November 2016 we rated this key question as 'requires improvement.' There continued to be improvements required.

Since our last inspection visit, the deputy manager who managed the first floor dementia unit had left the home; and five weeks prior to our inspection visit the registered manager left their employment at the home without working their notice. Since then, the assistant manager has acted as manager and the previous administrator has acted as assistant manager. Both were overseen by the provider's operational director who was a registered nurse.

During this inspection we found the home continued to require improvements. This was the third inspection where we did not find the overall quality of care to be 'good'. This was because we had identified areas where risks had not been appropriately managed; there had been a lack of continuity of care in the last year because of the number of staff leaving and the use of agency staff; there was a breach of Regulation 11, Consent to Care and treatment; and complaints had not been managed well.

The provider had checks to monitor the quality of the service. These included the auditing of accidents and incidents, complaints, and medicines in the home. However this did not include checks to determine whether airflow mattresses were at the correct setting.

Quality checks that had taken place had mostly been completed, but it was not clear by looking at the records whether actions which required addressing had been addressed. We looked at the operational director's last visit report to the home, and they had also identified this and stressed the importance of monitoring action plans.

This was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated activities) Regulations 2014: Good Governance.

The acting assistant manager and acting manager had been working hard with the operational director in the last five weeks to stabilise the home and identify areas of work which had not been carried to the level expected of the provider. They had also worked hard to reduce the number of agency staff. We were told that some staff who had left the service had recently asked to return.

The acting assistant manager and acting manager were both enthusiastic although realistic about their current knowledge base and the learning they needed to undertake to support the home in a management capacity. The operational director gave assurances to us they would provide the additional support required until both were competent to manage the home. Care staff told us they were happy with the new management arrangement. They felt the new managers listened to them and provided good support to them. They said the morale of the care staff team had recently significantly improved. One member of staff told us, "Communication is good. When I first started it wasn't good, now it is getting a lot better." Another said, "We're getting there. I didn't get much support from the (previous) manager; she didn't really want to

know. The new management team are really approachable."

Whilst communication between staff and managers had improved, from speaking with care staff there appeared to be some areas where communication between care staff and nursing staff needed improvement. The operational director told us they were aware of these concerns and were working with the staff at the home to improve relationships.

Staff told us they felt listened to. We were aware the regional manager had listened and acted on staff concerns after a visit they made to the service in September 2017. Since then, management had continued to listen and respond to staff. One member of staff told us that previously they had asked for more resources and activities for people who lived on the dementia unit and they had not received them. They said they had recently been provided with these resources.

We asked three staff if the home would pass 'The mum test' (whether they would be happy for their relation to live at the home). One staff member said they would, whereas two said the home was almost there. They felt more recently it was moving in the right direction and they hoped that soon they would feel able to say yes to this question.

The provider also sent out questionnaires. These asked for people's views on what the service did well and what they could improve. Only one of the people and relatives we spoke with during our visit had completed a questionnaire.

The provider had a responsibility to inform the public of the CQC's most recent rating of the service. The rating of the home's performance had been displayed in the reception area of the home and the provider had published the most recent rating of Norton Grange on its website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent One person who had been assessed as having mental capacity was being deprived of their liberty to freely leave the home on their own. They did not consent to being escorted outside of the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has been rated as 'requires improvement' three times. This means governance has not been sufficiently robust to drive improvements.